UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

NICOLE HALL, as Administratrix of the Estate of Amir Hall,

Plaintiff,

-against-

THE NEW YORK STATE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, THE NEW YORK STATE OFFICE OF MENTAL HEALTH, BRIAN FISCHER, MICHAEL F. HOGAN, DANIEL J. KANE, JOHN P. DISCHIAVO, DAVID A. BUCKBEE, ROY JOHNSON, PAUL E. LASHWAY, ROBERT T. EVANS, MICHAEL P. HUSNAY, JAMES R. TEDESCO, JOSEPH P. NORWICH, CHARLES KELLY, WILLIAM HULIHAN, LEWIS RICHARD DAVIS, LYUBOV SAVITSKIY, ZOE KINGSLEY, SERGEANT J. KILBURN, SARAH NELSON, YOLANDA PERONI, MARILYN STEMEN, NICOLE HUNTER, KELLY DEHIMER, JULIE HUTCHINSON, DOWNSTATE/DOCCS JANE AND JOHN DOES #1-10, DR. ROBERT BAKALL, SHANNAN SULLIVAN, DR. LAWRENCE FARAGO, JILL PORTER, KAREN TORTELET, LORI CUNNINGHAM, MID-STATE/MEDICAL JANE AND JOHN DOES #1-10, LIEUTENANT DERIDER, LIEUTENANT DUBERNECKI, D.S.S. WARD, CAPTAIN CHRISTOPHER J. HOLMER, MID-STATE/DOCCS JANE AND JOHN DOES #1-10, DR. DANIELLE DILL-LEWIS, GREAT MEADOW/DOCCS JANE AND JOHN DOES #1-10,

Defendants.

FIRST AMENDED COMPLAINT

12-CV-0377 (GTS/DEP)

Jury Trial Demanded

Plaintiff Nicole Hall ("Plaintiff") resides in Albany, New York. Plaintiff, as Administratrix of the Estate of Amir Hall, by her undersigned attorneys, for her complaint against defendants the New York State Department of Corrections and Community Supervision,

the New York State Office of Mental Health, Brian Fischer, Michael F. Hogan, Daniel J. Kane, John P. Dischiavo, David A. Buckbee, Roy Johnson, Paul E. Lashway, Robert T. Evans, Michael P. Husnay, James R. Tedesco, Joseph P. Norwich, Charles Kelly, William Hulihan, Lewis Richard Davis, Lyubov Savitskiy, Zoe Kingsley, Sergeant J. Kilburn, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Downstate/DOCCS Jane and John Does #1-10, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Mid-State/Medical Jane and John Does #1-10, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, Mid-State/DOCCS Jane and John Does #1-10, and Dr. Danielle Dill-Lewis, alleges upon personal knowledge as to herself, her own conduct, and Amir's personal background, and upon information and belief as to all other matters, as follows:

I. PRELIMINARY STATEMENT

1. Amir Hall died by hanging, an apparent suicide, on June 20, 2010, while housed in isolated confinement in the Special Housing Unit (the "SHU") at the Great Meadow Correctional Facility.[1] At the time, he had been incarcerated for thirteen months, at Great Meadow and other correctional facilities in New York State (the "State").

2. Amir was only 23 years old at the time of his death. He had a long history of serious mental illness. The State was well aware of Amir's history of mental illness, but misdiagnosed him and failed to provide him with minimally adequate mental health treatment. The failure to provide adequate treatment led to a further deterioration of his already weakened mental condition.

[1] All of the documentation received thus far indicates that Amir's death was self-inflicted. Accordingly, Plaintiff has assumed, for purposes of the allegations in this Complaint, that Amir died by suicide. Plaintiff reserves the right to amend her complaint as appropriate if, during the course of discovery, facts come to light that call into question whether Amir's death was self-inflicted.

3. Compounding its failure to properly diagnose and treat Amir, during the four months immediately preceding his death, Defendants took punitive action against Amir by placing him in isolated confinement on at least four separate occasions. In fact, on the date of his death, Amir had just recently begun a seven month stint in SHU.

4. Throughout Amir's incarceration, Defendants repeatedly failed to provide proper medical care and treatment; failed to provide proper continuity of care and treatment; failed to follow internal policies and protocols; and were otherwise negligent towards Amir, including by acting or failing to act in ways that were detrimental to his mental health and his well-being, which led to his death by hanging on June 20, 2010.

5. On behalf of Amir and his family, the Administratrix of his estate brings this action for deliberate indifference to Amir's medical needs; discrimination on the basis of Amir's mental illness; negligence; ministerial neglect; medical malpractice, including malpractice in the provision of mental health services; wrongful death; and violations of the Constitution of the State of New York.

II. JURISDICTION

6. This action arises under the Eighth and Fourteenth Amendments to the United States Constitution, 42 U.S.C. § 1983, the Americans with Disabilities Act, the Rehabilitation Act, the New York State Constitution, and state common law.

7. The Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1343. The Court has supplemental jurisdiction over the state law claims pursuant to 28 U.S.C. § 1367.

8. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b).

III. PARTIES AND RELEVANT NON-PARTIES

9. Plaintiff Nicole Hall, Amir's mother, currently resides in Albany, New York. Plaintiff was issued Letters of Administration with respect to Amir's estate by the Surrogate's Court of Albany County on September 14, 2011.

10. At the time of his death, Amir Hall was an inmate housed at Great Meadow Correctional Facility, 11739 State Route 22, P.O. Box 51, Comstock, New York 12821-0051. His Department Identification Number was 08A0024.

11. Defendant the Department of Corrections and Community Supervision ("DOCCS") is a department of the State responsible for the operation and maintenance of all State correctional facilities.

12. Defendant Brian Fischer is the Commissioner of DOCCS. He is responsible for the operation and administration of all facilities within DOCCS. He is sued in his individual capacity.

13. Defendant the Office of Mental Health ("OMH") is an agency of the State responsible for the operation and maintenance of State psychiatric and mental health centers.

14. Defendant Michael F. Hogan is the Commissioner of OMH. He is responsible for the operation and administration of all OMH facilities within the department, including the Central New York Psychiatric Center. He is sued in his individual capacity.

15. The Central New York Psychiatric Center ("CNYPC") is an OMH-operated inpatient DOCCS hospital located in Marcy, New York. CNYPC provides inpatient health-care services to State prisoners with psychiatric problems at the hospital and outpatient services to prisoners in mental health units throughout DOCCS prisons.

16. Defendant Sarah Nelson is a Psychiatrist 2 employed by OMH and staffed at CNYPC. Sarah Nelson diagnosed and treated Amir while he was a patient at CNYPC, learned of

his history with sexual abuse, decided not to treat his sexual abuse through counseling, and subsequently discharged Amir from inpatient care at CNYPC. Unless otherwise noted, Sarah Nelson is sued in her individual capacity.

17. Defendant Yolanda Peroni is a Social Worker employed by OMH and staffed at CNYPC. Yolanda Peroni diagnosed and treated Amir while he was a patient at CNYPC, learned of his history with sexual abuse, decided not to treat his sexual abuse through counseling, and subsequently discharged Amir from inpatient care at CNYPC. Unless otherwise noted, Yolanda Peroni is sued in her individual capacity.

18. Defendant Marilyn Stemen is a Nurse Practioner employed by OMH and staffed at CNYPC. Marilyn Stemen diagnosed and treated Amir while he was a patient at CNYPC, learned of his history with sexual abuse, decided not to treat his sexual abuse through counseling, and subsequently discharged Amir from inpatient care at CNYPC. Unless otherwise noted, Marilyn Stemen is sued in her individual capacity.

19. Defendant Nicole Hunter is a Social Worker 1 employed by OMH and staffed at CNYPC. Nicole Hunter diagnosed and treated Amir while he was a patient at CNYPC, learned of his history with sexual abuse, decided not to treat his sexual abuse through counseling, and subsequently discharged Amir from inpatient care at CNYPC. Unless otherwise noted, Nicole Hunter is sued in her individual capacity.

20. Defendant Kelly DeHimer is a Nurse 2 Psych/Supervisor employed by OMH and staffed at CNYPC. Kelly DeHimer diagnosed and treated Amir while he was a patient at CNYPC, learned of his history with sexual abuse, decided not to treat his sexual abuse through counseling, and subsequently discharged Amir from inpatient care at CNYPC. Unless otherwise noted, Kelly DeHimer is sued in her individual capacity.

21. Defendant Julie Hutchinson is a Nurse 2 employed by OMH and staffed at CNYPC. Julie Hutchinson diagnosed and treated Amir while he was a patient at CNYPC, learned of his history with sexual abuse, decided not to treat his sexual abuse through counseling, and subsequently discharged Amir from inpatient care at CNYPC. Unless otherwise noted, Julie Hutchinson is sued in her individual capacity.

22. Downstate Correctional Facility ("Downstate") is a maximum security facility operated by DOCCS and located in Fishkill, New York.

23. Defendants Downstate/DOCCS Jane and John Does #1-10 (collectively the "Downstate/DOCCS Jane and John Does") are the DOCCS employees at Downstate who failed to timely provide Amir with his required interview and assessment by his assigned corrections counselor. Unless otherwise noted, the Downstate/DOCCS Jane and John Does are sued in their individual capacities. Their identities will be ascertained during discovery.

24. Defendant Dr. Robert Bakall is a doctor employed by OMH and staffed at Downstate. Dr. Robert Bakall diagnosed and treated Amir's mental illness while he was incarcerated at Downstate. Unless otherwise noted, Dr. Robert Bakall is sued in his individual capacity.

25. Shannan Sullivan is a Psychology Assistant 3 employed by OMH and staffed at Downstate. Shannan Sullivan assisted in the diagnosis and treatment of Amir's mental illness while he was incarcerated at Downstate. Unless otherwise noted, Shannan Sullivan is sued in her individual capacity.

26. Mid-State Correctional Facility ("Mid-State") is a medium security facility operated by DOCCS and located in Marcy, New York.

27. Defendant William Hulihan was the Superintendant of Mid-State when Amir was incarcerated in that facility. He is sued in his individual capacity.

28. Dr. Lawrence Farago is a doctor employed by OMH and staffed at Mid-State. Dr. Lawrence Farago diagnosed and treated Amir's mental illness while he was incarcerated at Mid-State. Unless otherwise noted, Dr. Lawrence Farago is sued in his individual capacity.

29. Jill Porter is an LMSW2, SHU Coordinator employed by OMH and staffed at Mid-State. Jill Porter assisted in the diagnosis and treatment of Amir's mental illness while he was incarcerated at Mid-State. Unless otherwise noted, Jill Porter is sued in her individual capacity.

30. Karen Tortelet is an NPP employed by OMH and staffed at Mid-State. Karen Tortelet assisted in the diagnosis and treatment of Amir's mental illness while he was incarcerated at Mid-State. Unless otherwise noted, Karen Tortelet is sued in her individual capacity.

31. Lori Cunningham is an LMSW/Social Worker II employed by OMH and staffed at Mid-State. Lori Cunningham assisted in the diagnosis and treatment of Amir's mental illness while he was incarcerated at Mid-State. Unless otherwise noted, Lori Cunningham is sued in her individual capacity.

32. Defendants Mid-State/Medical Jane and John Does #1-10 (collectively the "Mid-State/Medical Jane and John Does") are the staff members at Mid-State who provided Amir with treatment for his physical ailments, including, but not limited to, his hypothyroidism. The Mid-State/Medical Jane and John Does are sued in their individual capacities. Their identities will be ascertained during discovery.

33. Defendant Lieutenant DeRider is a Lieutenant employed by DOCCS and staffed at Mid-State. Lieutenant DeRider is the Hearing Officer who sentenced Amir to time in the SHU on or about February 17, 2010 and April 20, 2010. Unless otherwise noted, Lieutenant DeRider is sued in his individual capacity.

34. Defendant Lieutenant Dubernecki is a Lieutenant employed by DOCCS and staffed at Mid-State. Lieutenant Dubernecki is the Hearing Officer who sentenced Amir to time in the SHU on or about March 12, 2010. Unless otherwise noted, Lieutenant Dubernecki is sued in his individual capacity.

35. Defendant Captain Christopher J. Holmer is a Captain employed by DOCCS and staffed at Mid-State. Captain Christopher J. Holmer is the Hearing Officer who sentenced Amir to time in the SHU on or about May 8, 2010. Unless otherwise noted, Captain Christopher J. Holmer is sued in his individual capacity.

36. Defendant D.S.S. Ward is employed by DOCCS and staffed at Mid-State. D.S.S. Ward is the Hearing Officer who sentenced Amir to time in the SHU on or about June 9, 2010. Unless otherwise noted, D.S.S. Ward is sued in his individual capacity.

37. Defendants Mid-State/DOCCS Jane and John Does #1-10 (collectively the "Mid-State/DOCCS Jane and John Does") are the DOCCS staff at Mid-State responsible for preparing Amir for his transfer from Mid-State to Great Meadow, and for processing Amir's transfer from Mid-State to Great Meadow. Unless otherwise noted, the Mid-State/DOCCS Jane and John Does are sued in their individual capacities. Their identities will be ascertained during discovery.

38. Defendant Lewis Richard Davis is a social worker employed by OMH and staffed at Mid-State. Lewis Richard Davis is sued in his individual capacity.

39. Defendant Lyubov Savitskiy is a nurse employed at Mid-State. Lyubov Savitskiy is sued in her individual capacity.

40. Defendant Daniel J. Kane is a Sergeant employed at Mid-State. Sergeant Kane is sued in his individual capacity.

41. Defendant John P. Dischiavo is a Lieutenant employed at Mid-State. Lieutenant Dischiavo is sued in his individual capacity.

42. Defendant David A. Buckbee is a Corrections Officer employed at Mid-State. Officer Buckbee is sued in his individual capacity.

43. Defendant Roy Johnson is a Corrections Officer employed at Mid-State. Officer Johnson is sued in his individual capacity.

44. Defendant Paul E. Lashway is a Corrections Officer employed at Mid-State. Officer Lashway is sued in his individual capacity.

45. Defendant Robert T. Evans is a Corrections Officer employed at Mid-State. Officer Evans is sued in his individual capacity.

46. Defendant Michael P. Husnay is a Corrections Officer employed at Mid-State. Officer Husnay is sued in his individual capacity.

47. Defendant James R. Tedesco is a Corrections Officer employed at Mid-State. Officer Tedesco is sued in his individual capacity.

48. Defendant Joseph P. Norwich is a Corrections Officer employed at Mid-State. Officer Norwich is sued in his individual capacity.

49. Great Meadow Correctional Facility ("Great Meadow") is a maximum security facility operated by DOCCS and located in Comstock, New York.

50. Defendant Charles Kelly was the acting Superintendant of Great Meadow at the time of Amir's death. He is sued in his individual capacity.

51. Dr. Danielle Dill-Lewis is a doctor employed by OMH and staffed at Great Meadow. Dr. Danielle Dill-Lewis failed to see Amir when he was transferred to Great Meadow. Unless otherwise noted, Dr. Danielle Dill-Lewis is sued in her individual capacity.

52. Defendants Great Meadow/DOCCS Jane and John Does #1-10 (collectively the "Great Meadow DOCCS Jane and John Does") are the DOCCS staff at Great Meadow responsible for processing Amir's transfer to that institution. Unless otherwise noted, the Great Meadow/DOCCS Jane and John Does are sued in their individual capacities. Their identities will be ascertained during discovery.

53. Defendant Zoe Kingsley was a nurse employed at Great Meadow. Zoe Kingsley is sued in her individual capacity.

54. Defendant Sergeant J. Kilburn is a Sergeant employed by DOCCS at Great Meadow. Sergeant Kilburn is sued in his individual capacity. His full identity will be ascertained during discovery.

IV. FACTUAL ALLEGATIONS

A. Background

55. Amir was born on September 1, 1986. He began receiving treatment for mental illness when he was nine years old. Prior to his arrest, Amir was hospitalized several times and also received outpatient services to treat his mental illness.

56. Amir attended Albany High School and then Harriet Gibbons High School, a learning community of Albany High School, which provided alternative-education programs. Amir earned his high school diploma from Harriet Gibbons and, prior to his incarceration, was enrolled in a nursing degree program at Maria College in Albany.

57. After being convicted for robbery in the third degree, Amir was sentenced to 16 to 48 months' imprisonment. He began serving his sentence on January 4, 2008.

58. After being released on parole, Amir lived with his sister. He worked first at Target and then at a Holiday Inn in Downtown Albany.

59. During an altercation at his sister's home in May 2009, Amir hit one of his sister's friends. The friend pressed charges.

60. On May 11, 2009, Amir was brought to Albany County Jail for violating parole.

B. Amir Displays Signs and Symptoms of Serious Mental Illness and Suicidal Ideation

61. While incarcerated at Albany County Jail, Amir displayed signs and symptoms of serious mental illness and suicidal ideation. Nevertheless, Albany County Jail failed to provide Amir with mental health treatment for the three and one-half months he was incarcerated in that facility.

62. Then, on August 31, 2009, Amir was transferred from Albany County Jail to CNYPC, the State's psychiatric institution for inmates. Upon his admission as an inpatient, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson diagnosed Amir as suffering from Major Depressive Disorder, single episode severe with psychotic features.

63. This was the first time since taking him into custody in May that State officials diagnosed Amir's serious mental illness. In the months that followed, and as detailed below, the respective OMH defendants would change Amir's diagnosis three more times. Despite the fact that they continued to alter Amir's diagnosis, none of the OMH defendants conducted formal psychological testing on Amir.

64. According to a report prepared after an investigation into Amir's death by the Commission on Quality of Care and Advocacy for Persons with Disabilities ("CQC"), Amir told

Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson that he was sexually abused by a neighbor when he was a teenager and that he himself had engaged in sexually abusive acts, though he was never convicted of, or charged with, a sexual offense. Amir also told Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson that he had attempted suicide "20 times" and that he was once hospitalized, following an attempted suicide, at the Capital District Psychiatric Center, an inpatient psychiatric treatment and rehabilitation center for patients who have been diagnosed with serious and persistent mental illness. The Capital District Psychiatric Center, like CNYPC, is operated by OMH.

65. After learning of Amir's history with sexual abuse, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson failed to complete a Trauma Assessment Form, as required by OMH policy.

66. Amir asked to be put into a sex offender treatment program, a request he would repeat several times throughout his incarceration. At no point did the respective CNYPC, OMH, or DOCCS defendants enroll Amir in the program.

67. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson failed to investigate or treat Amir's history of sexual abuse through counseling because they determined, incorrectly and without explanation, that it would be inadvisable to do so. As detailed below, Amir's counselor at Downstate later stressed Amir's need to participate in sex offender counseling (among other forms of counseling). Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham and the Mid-State/DOCCS Jane and John Does failed to provide this counseling, even after it was finally recommended by Amir's counselor to treat his mental illness.

68. On November 3, 2009, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson discharged Amir and DOCCS transferred him to Downstate.

69. Upon information and belief, DOCCS, OMH, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson failed to complete the required Trauma Assessment Form, failed to treat Amir's history of sexual abuse through counseling, discharged Amir from CNYPC inpatient care, and took other actions or failed to take other actions that were deleterious to Amir's mental health because of his mental illness.

70. Upon information and belief, DOCCS, OMH, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson were motivated by discriminatory animus and/or ill will because of Amir's mental illness when they took the actions described in the preceding paragraph, as well as other actions and failures to act.

71. In Amir's discharge plan from CNYPC, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson recommended that Amir participate in a Transitional Intermediate Care Program ("TrICP"), which is a residential mental health treatment unit where inmate-patients with serious mental illness are housed separately from other inmates in general population. The inmate-patients in TrICP participate in bi-weekly group counseling sessions aimed at helping them adjust to the regular prison environment. Some of the TrICP programming will be with the general population, but they are provided separate housing and separate counseling by OMH and DOCCS staff.

72. Contrary to the express recommendation for TrICP in the CNYPC discharge plan, Amir was not placed into the TrICP or any other appropriate residential mental treatment unit within the prisons. DOCCS, OMH, the Downstate/DOCCS Jane and John Does, Dr. Robert

Bakall, Shannan Sullivan, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham, without explanation, failed to follow Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson's recommendation and offer Amir participation in a TrICP program.

C. Dr. Robert Bakall and Shannan Sullivan Fail To Treat Amir Properly

73. After CNYPC discharged Amir and DOCCS transferred him to Downstate, Dr. Robert Bakall and Shannan Sullivan, incorrectly and without explanation, changed Amir's diagnosis from Major Depressive Disorder, single episode severe with psychotic features, to Polysubstance Dependence and Borderline Personality Disorder and ignored the discharge plan recommendation for TrICP.

74. Dr. Robert Bakall and Shannan Sullivan also gave Amir a Mental Health Service Level ("MHSL") designation of "1." All inmates are assigned a MHSL. The levels range from 1 to 6. MHSL 1 is the most serious designation an inmate can receive. It is assigned to inmates who suffer from a major or serious mental illness, who have active symptoms requiring treatment, and who have not had six months of psychiatric stability. The MHSL classification is an important criteria for determining where an inmate will be housed.

75. On November 13, 2009, less than two weeks after his transfer to Downstate and his initial diagnosis, Dr. Robert Bakall and Shannan Sullivan, again incorrectly and without explanation, changed Amir's diagnosis. This time his diagnosis was changed to Adjustment Disorder with mixed disturbances of emotions and conduct, Alcohol Dependence, Cannabis Dependence, and Personality Disorder Not Otherwise Specified. Dr. Robert Bakall and Shannan Sullivan again designated Amir as MHSL 1.

76. Despite Amir's recent inpatient treatment and diagnosis with a serious mental illness, the Downstate/DOCCS Jane and John Does failed to have Amir interviewed and assessed

by an assigned corrections counselor within the first five days following his transfer to Downstate as required by DOCS Directive #4401. Amir remained at the highest needs level, MHSL 1, yet required protocols were ignored. The failure of the Downstate/DOCCS Jane and John Does to provide the required and necessary assessment after a transfer from an inpatient psychiatric hospital (CNYPC) continued for five weeks. During Amir's first five weeks at Downstate, he did not have access to an assigned corrections counselor. After five weeks of incarceration, and 20 weeks after he was first put back in State custody, Amir was finally provided the interview and assessment that was supposed to occur within five days of his transfer to Downstate from CNYPC.

77. Results of this assessment directly contradicted the recommendation of Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson, who ruled out sex offender counseling. Amir's counselor at Downstate determined that Amir needed to participate in (1) sex offender counseling; (2) an Aggression Replacement Training ("ART") program; (3) suicide prevention counseling; and (4) that he needed to be prescribed "psych meds on [a] permanent basis."

78. As detailed below, however, even after the assessment, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Mid-State/DOCCS Jane and John Does, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis failed to enroll Amir in sex offender counseling or an ART program and failed to provide Amir with sufficient suicide prevention counseling. Although Dr. Robert Bakall and Shannan Sullivan prescribed Amir some unidentified medication to treat his depression, Dr. Lawrence Farago, Jill Porter, Karen Tortelet,

and Lori Cunningham subsequently determined that the medication was ineffective for treating depression, discontinued its use and failed to prescribe a replacement.

79. Upon information and belief, DOCCS, OMH, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, and Shannan Sullivan failed to provide Amir with a timely interview and assessment; failed to house Amir in a residential mental health program (such as the TrICP); failed to enroll Amir in a sex offender treatment program, an ART program, or suicide prevention counseling; and took other actions or failed to take other actions that were deleterious to Amir's mental health because of his mental illness.

80. Upon information and belief, DOCCS, OMH, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, and Shannan Sullivan were motivated by discriminatory animus and/or ill will because of Amir's mental illness when they took the actions described in the preceding paragraph, as well as other actions and failures to act.

81. On December 10, 2009, DOCCS transferred Amir from Downstate to Mid-State. DOCCS transferred Amir to Mid-State specifically so that he could participate in a sex offender treatment program and an ART program offered at that facility.

82. Even after being transferred to Mid-State, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to enroll Amir in the sex offender treatment program and the ART program.

D. Amir Receives Inadequate Mental Health and Medical Treatment and is Inappropriately Placed in Isolated Confinement in the Special Housing Unit While His Mental Condition Deteriorates

83. Although Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham provided some mental health services to Amir, they did not permit Amir to personally participate in formulating his treatment plan as required by OMH policy.

84. On January 2, 2010, shortly after arriving at Mid-State, Amir informed an unidentified nurse that he was having suicidal thoughts. As a result, the nurse informed Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham and they transferred Amir to Mid-State's Residential Crisis Treatment Program ("RCTP") for suicidal ideation.

85. OMH and/or DOCCS transfers inmates to a facility's RCTP only if they need an immediate mental health evaluation and/or observation and treatment. In the RCTP, the State is supposed to provide inmates with comprehensive treatment in an environment that is designed to ensure the inmate's safety, both from himself and from fellow inmates.

86. As part of his transfer to the RCTP in January, 2010, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham placed Amir in an observation cell on a suicide watch. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham subsequently discharged Amir from the RCTP and transferred him back into the general population.

87. Shortly after he was discharged from the RCTP, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham determined that the medication previously prescribed to treat Amir's depression was properly used as a sleep-aid and not effective for treating depression. Despite a serious continuing deterioration of his mental condition, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham discontinued Amir's medication at that time, failed to prescribe alternative medication to treat Amir's depression, and failed to consider or provide any alternative anti-depressive therapy.

88. While at Mid-State, the Mid-State/Medical Jane and John Does failed to inform Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham about important medical information and changes in Amir's medical medication. For example, the Mid-State/Medical

Jane and John Does did not communicate to Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham that Amir was diagnosed with hypothyroidism and prescribed Synthroid®.

89. Hypothyroidism is a condition where the thyroid gland does not make enough thyroid hormone. It is often associated with depression and anxiety, and possible side effects from taking Synthroid® include nervousness and sleeplessness. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham needed this information to diagnose and treat Amir's mental illness properly.

90. Additionally, Amir did not consistently take medication prescribed to him by the Mid-State/Medical Jane and John Does. Again, the Mid-State/Medical Jane and John Does failed to inform Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham of this information, which was relevant to Amir's mental health diagnosis and treatment.

91. Shortly after arriving at Mid-State, Amir began to act out by violating prison rules. This conduct was uncharacteristic of Amir, who had not previously received any write-ups for disciplinary behavior during his incarceration.

92. For example, in early January 2010, the Mid-State/DOCCS Jane and John Does gave Amir a disciplinary write-up for losing/damaging property. Then, on January 29, 2010, the Mid-State/DOCCS Jane and John Does again wrote Amir up, this time for having property in an unauthorized location, for smuggling property, and for changing identification (presumably with another inmate).

93. As a result of these infractions, Lieutenant DeRider held a disciplinary hearing on February 17, 2010, and punished Amir by sentencing him to 21 days in isolated confinement in SHU.

94. SHUs are a form of isolated or solitary confinement where inmates are punished for rules infractions and housed separately from the general prison population. While housed in SHU, an inmate spends 23 hours isolated in an indoor cell and is alone outside for one hour in an small, caged area. SHU confinement is "almost guaranteed to worsen the mental condition of just about anyone but certainly those with vulnerable psyches."[2]

95. On March 12, 2010, shortly after being released from SHU, the Mid-State/DOCCS Jane and John Does again wrote Amir up for a rule violation, this time because he was involved in an altercation with a fellow inmate.

96. Lieutenant Dubernecki again punished Amir by transferring him to SHU. The exact length of this SHU sentence is not currently known, but, upon information and belief, it was for approximately 30 days. This meant that of the preceding 53 days, Amir spent approximately 51 of them in isolated confinement.

97. Amir's release from SHU was short-lived. Lieutenant DeRider sent him back to isolated confinement on April 20, 2010, again to punish him for getting into an altercation with another inmate. Again, the exact length of this transfer is not currently known, but, upon information and belief, it was for approximately 45 days. Thus, Amir spent a total of 98 days in isolated confinement during a 107-day period.

98. While in SHU, Amir continued to act out and continued to be written up for rules infractions. On May 8, 2010, Amir threw an unknown liquid on an officer making rounds past his cell. Captain Christopher J. Holmer charged Amir with Assault on Staff and Unhygienic Act.

99. Approximately one month later, on June 2, 2010, Amir again threw liquid, later determined to be Kool-Aid, on another officer.

[2] Statement by then-District Court Judge Gerard Lynch during an April 27, 2007 conference held in connection with Disability Advocates, Inc. v. N.Y. State Office of Mental Health, 02-CV-4002 (S.D.N.Y.) (GEL).

100. D.S.S. Ward held a disciplinary hearing on June 9, 2010. D.S.S. Ward sentenced Amir to seven months in SHU.

101. The Mid-State/DOCCS Jane and John Does had not transferred Amir out of SHU following his April 20, 2010 confinement. Thus, the seven months SHU time was on top of the approximate 45 day punishment Amir was in the process of serving. Had Amir not died on June 20, 2010, he would have spent 312 out of 326 days in SHU upon completing this seven month sentence.

102. Because of the severity of the conditions and the known psychiatric harm that may result from isolated confinement, inmates with serious mental illness housed in SHU were required to receive two hours per day of out-of-cell therapeutic programming and mental health treatment five days per week. (Disability Advocates, Inc. v. N.Y. State Office of Mental Health, Private Settlement Agreement, at 2-3, attached hereto as Exhibit A.)

103. Amir was not provided this heightened level of care because his diagnosis was changed inappropriately and because Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to recognize and respond to his psychiatric deterioration in SHU. Amir's MHSL level remained high (MHSL level 1 or 2), yet he was not afforded needed treatment.

104. In addition to the requirements mandated by the Private Settlement Agreement, OMH staff are supposed to make daily SHU rounds and are supposed to offer all inmates housed in SHU private, out-of-cell encounters with OMH clinicians on a bi-weekly basis.

105. While in the harsh isolated confinement of SHU, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to see Amir on the required daily OMH rounds and failed to offer Amir the required private out-of-cell sessions.

106. Amir's sudden behavioral problems were clear signals that his mental health was deteriorating and that he was at an increased risk for self-harm and suicide. Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham deliberately ignored the evidence that Amir was spiraling downward, ignored the medical significance of Amir's behavior and instead responded punitively by placing Amir in SHU on at least four occasions. In SHU, Amir's under-treated, serious mental illness was further exacerbated and his poor psychiatric condition deteriorated further without intervention by Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham.

107. In addition, the Mid-State/DOCCS Jane and John Does and Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham never enrolled Amir in a sex offender treatment program, an ART program, or suicide prevention counseling even though he was transferred to Mid-State for the express purpose of participating in those programs, and even though he repeatedly requested to be placed in a sex offender treatment program.

108. Upon information and belief, DOCCS, OMH, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, and the Mid-State/DOCCS Jane and John Does failed to house Amir in a residential mental health treatment program (such as TrICP); failed to enroll Amir in a sex offender treatment program, an ART program, or suicide prevention counseling; failed to provide Amir with reasonable accommodations so that he could have access to these and other services and programs while he was housed in SHU; transferred Amir to SHU on at least four separate occasions; discontinued Amir's prescribed psychiatric medication; and took other

actions or failed to take other actions that were deleterious to Amir's mental health because of his mental illness.

109. Upon information and belief, DOCCS, OMH, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, and the Mid-State/DOCCS Jane and John Does were motivated by discriminatory animus and/or ill will because of Amir's mental illness when they took the actions described in the preceding paragraph, as well as other actions and failures to act.

110. On April 8, 2010, while Amir was being transferred into and out of SHU, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham changed Amir's diagnosis for the third time, this time to Polysubstance Dependence and Borderline Personality Disorder.

111. As of April 8, 2010, Amir remained designated a MHSL 1; however, on June 4, 2010, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham changed his designation to MHSL 2 after incorrectly determining that he lacked the symptoms to support an MHSL 1 designation.

112. MHSL 2 is assigned to individuals who, like MHSL 1 designees, suffer from a major/serious mental illness, but who, unlike MHSL 1 designees, have no significant active symptoms, have been compliant with their treatment and medication for one year, and have experienced six months of psychiatric stability.

113. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham incorrectly changed Amir's MHSL from 1 to 2 on June 4, 2010. At the time, Amir was suffering from active symptoms, was not complying with his treatment or medication requirements during the preceding year, and had not experienced six months of psychiatric stability. In fact, during the months immediately preceding the downgrade, Lieutenant DeRider, Lieutenant Dubernecki,

D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to enroll Amir in the treatment programs recommended by his OMH clinicians and corrections counselors, transferred him to RCTP for suicidal ideation and placed him on a suicide watch, routinely transferred him to SHU as punishment for symptomatic anti-social behavior that resulted from his mental health condition, discontinued his prescribed medication and failed to prescribe an alternative medication, and otherwise ignored Amir's seriously deteriorating mental condition and the seriousness of his mental illness.

114. From the day he was first put into isolated confinement, on February 17, 2010, to the day he died, Amir spent 114 of 123 days in the SHU. That is, for those 114 days, Amir was alone every day for 23 hours in a tiny cell and for one hour in an outside pen. During this same period of time Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham changed Amir's diagnosis from Adjustment Disorder with mixed disturbances of emotions and conduct, Alcohol Dependence, Cannabis Dependence, and Personality Disorder Not Otherwise Specified, to Polysubstance Dependence and Borderline Personality Disorder. In addition, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham downgraded Amir from a 1 to a 2 MHSL designation. During this same period of time, Amir's mental illness was left untreated. And during this same period of time, culminating in his death, his mental health, already known to be fragile, was predictably and fatally worsening.

E. Defendants Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, and Norwich Forcibly Extract Amir from His Cell with a Chemical Agent

115. After the June 9, 2010 disciplinary hearing, DOCCS scheduled Amir for a SHU-to-SHU transfer from Mid-State to Great Meadow to complete his seven-month SHU sentence. The transfer was scheduled for Friday, June 18, 2010.

116. At approximately 8:20 a.m. on that day, the Mid-State/DOCCS Jane and John Does told Amir to "accept draft" and prepare to leave. Amir did not speak to the Mid-State/DOCCS Jane and John Does. The Mid-State/DOCCS Jane and John Does ordered Amir to leave his cell several times. Amir did not reply or leave his cell.

117. The Mid-State/DOCCS Jane and John Does contacted OMH for assistance.

118. Lewis Richard Davis, an OMH social worker, went to SHU and attempted to talk with Amir for approximately 10 to 15 minutes. Before responding to SHU, Lewis Richard Davis checked Amir's file and was aware of his psychiatric history, including his history of suicide attempts. Amir did not speak to Lewis Richard Davis Instead, he remained silent on his bed with a sheet over his head during the entire encounter.

119. The Mid-State/DOCCS Jane and John Does ordered Amir to leave his cell several more times. Eventually, Superintendent William Hulihan authorized a forcible cell extraction through the use of chemical agents. An extraction team comprised of defendants Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, and Norwich were sent to Amir's cell.

120. Upon information and belief, Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, and Norwich were aware that Amir suffered from a serious mental illness, that he was a suicide risk, and/or that he was a risk for self-harm.

121. Lashway administered one burst of chemical agents from a 587 aerosol canister. When Amir did not leave his cell, Lashway administered a second burst of the chemical agent. Again, Amir did not leave his cell. Lashway administered a third burst of the chemical agent. Amir complied after the third burst and was forcibly extracted from his cell.

122. Although the exact chemical agent used is not currently known, upon information and belief, Lashway used pepper spray or a similar agent to forcibly extract Amir from his cell. This caused Amir severe pain and discomfort.

123. After being forcibly extracted from his cell, Amir was physically examined by defendant Lyubov Savitskiy. Savitskiy did not do a mental health assessment or provide counseling to Amir.

124. Even though Amir remained silent throughout the encounter, had to be forcibly extracted from his cell, and was examined by a nurse for physical injuries, the Mid-State/DOCCS Jane and John Does, Lewis Richard Davis, Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, Norwich, and Savitskiy all failed to have Amir examined by an OMH staff member, a psychiatrist, a mental health clinician, or any other counselor after the cell extraction. Moreover, Lewis Richard Davis, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to intercede on Amir's behalf, examine Amir following the extraction, or complete a mental health progress note regarding the extraction or Lewis Richard Davis's attempted interview of Amir.

F. Amir's Transfer to Great Meadow

125. Because of the forced chemical extraction, Amir missed the scheduled draft bus and was transported to Great Meadow by State van.

126. Even though there had been a dramatic event prior to transfer, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to complete Amir's Termination/Transfer Progress notes prior to transferring Amir to Great Meadow.

127. Amir arrived at Great Meadow at approximately 2:15 p.m., after Dr. Danielle Dill-Lewis had already made her daily rounds in SHU. The Great Meadow/DOCCS Jane and

John Does processed him as a SHU to SHU transfer. During the transfer process, Amir was nervous, quiet, and non-responsive.

128. Upon information and belief, DOCCS, OMH, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis failed to house Amir in a residential mental health program (such as the TrICP); failed to enroll Amir in a sex offender treatment program, an ART program, or suicide prevention counseling; and took other actions or failed to take other actions that were deleterious to Amir's mental health because of his mental illness.

129. Upon information and belief, DOCCS, OMH, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis were motivated by discriminatory animus and/or ill will because of Amir's mental illness when they took the actions described in the preceding paragraph, as well as other actions and failures to act.

130. The Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to inform Great Meadow and/or the OMH staff at Great Meadow about Amir's refusal to leave his cell, about the forced chemical extraction, or about Amir's late transfer by State van.

131. Neither the Great Meadow/DOCCS Jane and John Does nor Dr. Danielle Dill-Lewis inquired as to why Amir was absent from the scheduled draft bus despite the fact that he was identified on the transfer list to be transported by bus.

132. As a result of this failure of communication between Mid-State and Great Meadow, Dr. Danielle Dill-Lewis failed to see Amir during her daily SHU rounds on the date of his transfer and failed to ensure that Amir was otherwise seen by OMH.

133. Zoe Kingsley, a nurse employed by DOCCS Health Services, falsely reported that she had administered a required health screening to Amir at the time he was received at Great

Meadow and that she had ordered an immediate referral to OMH. Zoe Kingsley, in fact, never met with Amir, never conducted the health screening, and never referred him to OMH.

134. Aside from the lie and attempted cover-up by Zoe Kingsley, the failure to evaluate Amir was itself a violation of DOCCS policy, which states: "[u]pon arrival at a DOCS [sic] facility, every newly received or transferred inmate will receive a health screening by an RN that includes an inquiry into the inmate's current and past health/mental health history and immediate referral of any inmate to a health provider if indicated." (A blank copy of the health screening form Zoe Kingsley should have administered is attached hereto as Exhibit B.) Had Zoe Kingsley performed the required health screen and inquired about Amir's mental health, she would have discovered, among other things, that he had been treated in an RCTP for suicidal ideation, that he attempted suicide 20 times, and that he had been receiving psychological medication, albeit intermittently.

135. Because of her deliberate false report and failure to see Amir, DOCCS Health Services terminated Zoe Kingsley from her position and subsequently referred her to the Office of Professional Discipline of the State Education Department.

136. Sergeant J. Kilburn is a sergeant employed by DOCCS at Great Meadow.

137. At approximately 2:30 p.m., Prior to admitting Amir into SHU, Sergeant Kilburn conducted the Suicide Prevention Screening Guidelines – SHU Admission pursuant to DOCCS protocol. Unlike Zoe Kingsley, Sergeant Kilburn did, in fact, see Amir prior to his admission into SHU.

138. Sergeant Kilburn asked Amir a series of scripted "yes" or "no" questions. Depending on Amir's responses, Sergeant Kilburn could make no referral to OMH, a "regular" referral to OMH, or an "immediate" referral to OMH. Although Sergeant Kilburn had some

discretion in determining what type of referral to make, he was required by DOCCS protocol to make an immediate referral to OMH if Amir answered "yes" to certain pre-identified questions indicating he was prone to suicide.

139. One such question is: "Do you feel like you have nothing to look forward to in the future?" When asked by Sergeant Kilburn, Amir answered "yes." Once Amir answered "yes," Sergeant Kilburn was obligated by DOCCS protocol to refer Amir to OMH immediately. Sergeant Kilburn failed to authorize an immediate referral to OMH.

140. Instead, Sergeant Kilburn ad-libbed, going off-script to ask Amir "if he really believed that there was nothing to live for." This was not one of the listed questions on the Suicide Prevention Screening Guidelines – SHU Admission and there is nothing in those Guidelines that instructs the Screening Person to re-phrase and/or re-ask questions following a clear "yes" or "no" response from an inmate.

141. After Sergeant Kilburn re-phrased and re-asked Amir if he thought he had nothing to live for, Amir equivocated. Sergeant Kilburn then indicated that Amir responded "no" to the question "Do you feel there is nothing to look forward to in the future?" This in fact was the very question to which Amir had already answered "yes."

142. Sergeant Kilburn thereafter made only a regular, as opposed to an immediate, referral to OMH. As a result, Amir was not immediately or timely seen by Dr. Danielle Dill-Lewis and instead had to wait until Monday for treatment (too late, as it turned out, to prevent his hanging). (A copy of the form Sergeant Kilburn filled-out while screening Amir is attached hereto as Exhibit C.)

143. OMH does not staff mental health clinicians at Great Meadow over the weekend. Accordingly, no OMH mental health clinicians were available to meet with Amir from Saturday,

June 19, 2010 (the day after his transfer) through Sunday, June 20, 2010 (the date of his apparent suicide).

144. On June 19, 2010, Amir refused a shower and all of his scheduled meals. He accepted breakfast on June 20, 2010, but then again refused lunch.

G. Amir's Apparent Suicide

145. On June 20, 2010, two days after he arrived at Great Meadow, Amir died by hanging.

146. According to CQC's investigation, Amir used a piece of his bed sheet as a garotte, tied it to the upper left hand side of his cell gate, secured it around his neck, and used his body weight to asphyxiate himself.

147. L. Mahoney, a corrections officer employed by DOCCS at Great Meadow, discovered Amir hanging from his cell while passing out hot water. Amir was non-responsive. Rather than immediately attempt to assist Amir, Mahoney left the area to inform the console officer and two other floor officers of the situation.

148. Mahoney and the initial responding staff then returned to Amir's cell. Mahoney reached through the feed-up port to Amir's cell and lifted Amir's body in an attempt to relieve the tension on Amir's neck.

149. After some time passed, additional responding staff members arrived at Amir's cell and cut Amir down with an emergency knife.

150. They attached an Automated External Defibrillator ("AED") to Amir's chest. An AED can be used to perform electrical shock therapy on individuals who are experiencing life threatening cardiac arrhythmias. After attaching the AED, it was determined that shock therapy was inadvisable. As a result, the responding staff proceeded to perform CPR on Amir.

151. Amir did not respond to the CPR. He was placed on a stretcher and taken to Glens Falls Hospital, where he was pronounced dead on arrival.

152. The improvised method of hanging described above caused a painful death by asphyxiation.

153. Amir was aware of the pain and suffering caused by the hanging prior to his death.

154. Throughout the course of his incarceration, Amir was aware of additional pain and suffering, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

155. At the time of his death, Amir's conditional release date was November 28, 2010 and his maximum expiration date was October 5, 2011. This means that Amir could have been paroled on November 28, 2010 and, in any event, would have been released from custody or parole no later than October 5, 2011.

H. Investigations by New York State Commission of Correction and New York State Commission on Quality of Care and Advocacy for Persons with Disabilities

156. Following Amir's apparent suicide, the New York State Commission of Correction ("COC") and the CQC commenced investigations into the circumstances leading up to Amir's death (copies of the COC and CQC reports are attached hereto as Exhibits D and E respectively).

157. The COC's report, though only made available to Plaintiff in heavily redacted form, shows that the respective DOCCS and OMH defendants violated numerous internal protocols, failed to treat Amir properly, and ignored recommendations provided by his doctors and counselors.

158. For example, the COC report notes that, despite "significant changes in [Amir's] mental status," his "continued . . . poor disciplinary behavior," his isolation in SHU, and his minimal family contact, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham failed to revise "his treatment plan and/or [make a] recommendation for evaluation for psychotropic medication intervention." (Ex. D at 17.)

159. In addition, the COC report notes that Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer's "punitive responses to [Amir's increasingly unstable behavior] led to further decompensation, while treatment interventions [by Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham] decreased." (Id. at 18.)

160. As a result of its investigation into Amir's death, the COC recommended several changes to DOCCS and OMH procedures and policies, including, but not limited to, recommending that OMH: (1) "review [Amir's] clinical care prior to transfer to Great Meadow [], specifically, his mental status changes with no revisions to his treatment plan"; and (2) "develop a policy and procedure" to formally notify a receiving facility when an inmate has a problematic transfer. (Id. at 18-20.)

161. The CQC report documents similar failures, and also recommends several changes to OMH and DOCCS procedures and policies as a result of its investigation. For example, the CQC's Medical Review Board determined that the OMH defendants' "mental health documentation lacked a rationale or detail for the change in [Amir's] diagnosis." (Ex. E, Letter Dated April 15, 2011 from Michelle Guerin to Richard Miraglia, at 4.)

162. In addition, the CQC report states that the OMH defendants violated OMH Policy #9.27 by failing to consistently document Amir's medical medications in his Psychiatric

Progress Notes and by discontinuing his psychiatric medication without documenting the justification in his Notes. (Id. at 3.)

163. Moreover, the CQC report recommends that OMH begin to staff mental health clinicians at MHSL 1 facilities, such as Great Meadow, over weekends. (Id. at 4.)

I. DOCCS, OMH, Fischer, Hogan, Hulihan, and Kelly Knew that Isolated Confinement Has Acute Adverse Impact on Inmates with Mental Illness, Including Heightened Risk of Suicide

164. Well before June 20, 2010, DOCCS, OMH, Fischer, Hogan, Hulihan, and Kelly had actual knowledge, through private litigation, public legislation, and DOCCS' own investigations, that placing inmates with mental illnesses, like Amir, into isolated confinement units causes severe mental deterioration of those inmates and significantly increases the likelihood that they will harm themselves and/or commit suicide. At the time of Amir's Death, DOCCS, OMH, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Fischer, Hogan, Hulihan, and Kelly, therefore, knew that placing Amir in SHU presented known suicide risks, risks which the aforementioned defendants ignored and left untreated.

165. For example, in May 2002, Disability Advocates, Inc., a non-profit advocate for individuals with disabilities, brought an action for injunctive relief against various State agencies and individuals (including OMH, DOCCS, and Fischer), seeking to end the State's practice of subjecting inmates with mental illness to lengthy periods in SHUs, which caused those inmates to suffer severe psychiatric deterioration, *including numerous deaths by suicide*. See Disability Advocates, Inc. v. N.Y. State Office of Mental Health, 02-CV-4002 (S.D.N.Y.) (GEL) (Complaint attached hereto as Exhibit F).

166. The State settled the Disability Advocates action prior to completing a trial. Per the terms of the settlement, the State agreed to, inter alia, implement new treatment programs for inmates suffering with mental illnesses who were confined in SHUs.

167. On January 28, 2008, former Governor Elliot Spitzer signed New York's "SHU Exclusion Law," codified at 2008 N.Y. Sess Laws 1 (the "SHU Exclusion Law") (attached hereto as Exhibit G).

168. Although it did not go into effect until January 2011, when passing the SHU Exclusion Law in 2008, the State recognized "the inhumanity and counterproductive nature of certain forms of punishment for inmates with serious mental illness" and sought "[t]o establish residential treatment programs that provide for the treatment and confinement of inmates with serious mental illness in a manner that is consistent with both the mental health treatment needs of such inmates and the safety and security of the facility." (Ex. G at 000006-000007.)

169. The State also found that mentally ill inmates placed in isolated confinement "engage in acts of self-mutilation and commit suicide at a rate three times higher than inmates in the general prison population," that "inmates with serious mental illness often experience a continuing cycle of mental deterioration in general population or when in solitary confinement," and that those inmates often bounce "like a ping pong ball . . . between punitive segregation and [CNYPC]." (Id. at 000007.)

170. As for its own investigations, in 2010, DOCCS released an "Inmate Suicide Report," which "examine[d] characteristics of 121 inmates who committed suicide in a Department of Correctional Services' facility during the years 2000-2009" (attached hereto as Exhibit H). According to the Report, 27% of inmate suicides in New York State during that

period were committed by inmates confined in SHUs. (Ex. H at 14.) Only 6% of all total inmates are housed in SHUs.

171. In addition, 36% of the inmates who committed suicide during that period were designated at either MHSL "1" or "2." (Id. at 15.) And "there was a substantially higher concentration of offenders who had recently transferred to a new correctional facility." (Id. at 13.)

172. Amir's death was one of four inmate suicides that occurred at Great Meadow in the six-week period between June 17, 2010 and July 11, 2010. Seventeen suicides occurred in State correctional facilities in 2010 alone, which was a 70% increase from 2009.

FIRST CLAIM FOR RELIEF

(42 U.S.C. § 1983 against Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Lewis Richard Davis, Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, Norwich, Savitskiy, Zoe Kingsley, and Sergeant J. Kilburn)

173. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 172 as if fully set forth in this paragraph.

174. At all relevant times, the aforementioned defendants were acting under color of state law.

175. The aforementioned defendants, by acting with deliberate indifference to Amir's serious medical needs, deprived Amir of the rights, remedies, privileges, and immunities guaranteed to every citizen in the United States, in violation of 42 U.S.C. § 1983, including, but not limited to, the rights guaranteed by the Eighth and Fourteenth Amendments to the United States Constitution.

176. The aforementioned defendants had knowledge of Amir's history of mental illness, suicide attempts, and/or sexual abuse. They knew that he was a risk for suicide or failed to discover that he was a risk for suicide.

177. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act:

(a) failing to complete a Trauma Assessment Form following discovery that Amir had been sexually abused, as required by OMH policy;

(b) failing to treat Amir's history of sexual abuse through counseling; and

(c) discharging Amir from inpatient care to Downstate.

178. The Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, and Shannan Sullivan acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to timely provide Amir with an interview and assessment by an assigned counselor, as required by DOCS Directive #4401; and by failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC to prison.

179. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, and Captain Christopher J. Holmer acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act:

(a) failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC to prison;

(b) failing to enroll Amir in a sex offender treatment program, an ART

program, or suicide prevention counseling;

(c) transferring Amir out of the RCTP and back into the general population;

(d) transferring Amir to SHU on at least four separate occasions;

(e) failing to provide Amir with required daily SHU cell side contact with an OMH mental health clinician;

(f) failing to offer Amir private out-of-cell encounters with OMH on a bi-weekly basis while he was in SHU;

(g) discontinuing Amir's prescribed psychiatric medication;

(h) failing to prescribe Amir alternative psychiatric medication or alternative anti-depression therapy;

(i) failing to inform Great Meadow of the need to forcibly extract Amir from his cell prior to his transfer

180. The Mid-State/DOCCS Jane and John Does, Lewis Richard Davis, Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, Norwich, and/or Savitskiy acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to ensure that Amir was seen by OMH staff or other mental health personnel following his forced cell extraction and by failing to ensure that Great Meadow was informed of the forced cell extraction.

181. Zoe Kingsley acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to administer the required health screening to Amir at the time he was received at Great Meadow, by falsely reporting that she had administered the required health screening, and by falsely reporting that she had immediately referred Amir to OMH.

182. Sergeant J. Kilburn acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to immediately refer Amir to OMH after he answered "yes" to the question: "Do you feel like you have nothing to look forward to in the future?" and by otherwise failing to immediately refer Amir to OMH.

183. As a direct and proximate result of the aforementioned acts and failures to act, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

184. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

SECOND CLAIM FOR RELIEF

(42 U.S.C. § 1983 against Fischer, Hogan, Hulihan, and Kelly)

185. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 184 as if fully set forth in this paragraph.

186. At all relevant times, the aforementioned defendants were acting under color of state law.

187. The aforementioned defendants, by acting with deliberate indifference to Amir's serious medical needs, deprived Amir of the rights, remedies, privileges, and immunities guaranteed to every citizen in the United States, in violation of 42 U.S.C. § 1983, including, but not limited to, the rights guaranteed by the Eighth and Fourteenth Amendments to the United States Constitution.

188. Fischer, Hogan, Hulihan, and Kelly developed and implemented a system of mental health care that they knew was contrary to good and accepted psychiatric treatment in

that it permits incarcerating patients with known mental illnesses into SHUs without providing them with adequate mental health treatment.

189. Fischer, Hogan, Hulihan, and Kelly knew that the system they developed and implemented caused mentally ill inmates to be incarcerated in SHUs even though such incarceration was known to have a debilitating effect on the inmates' psychiatric well-being. The actions by Fischer, Hogan, Hulihan, and Kelly led to an increased risk of suicide among mentally ill inmates who were incarcerated in SHUs.

190. By implementing and effecting such a policy, Fischer, Hogan, Hulihan, and Kelly demonstrated deliberate indifference towards Amir's serious medical needs, including his increased risk of self-harm and/or suicide.

191. In addition, Fischer, Hogan, Hulihan, and Kelly acted with deliberate indifference to Amir's serious medical needs by failing to adequately train and supervise Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Lewis Richard Davis, Kane, Dischiavo, Buckbee, Johnson, Lashway, Evans, Husnay, Tedesco, Norwich, Savitskiy, Zoe Kingsley, and Sergeant J. Kilburn regarding, among other things,:

(a) following and implementing DOCCS and OMH policies;

(b) documenting all treatment and changes in treatment;

(c) communicating all treatment and changes in treatment to all necessary employees;

(d) evaluating inmates, including inmates with mental illnesses, for suicide

risk;

(e) recognizing signs of suicide risks among inmates, including inmates with mental illnesses;

(f) diagnosing and treating inmates with mental illnesses;

(g) ensuring that inmates' psychiatric care, diagnoses, and/or treatment remains consistent during and after facility transfers;

(h) screening inmates for suicidal tendencies upon entry into SHUs; and

(i) processing inmates during transfers among facilities.

192. As a direct and proximate result of the aforementioned acts and failures to act, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

193. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

THIRD CLAIM FOR RELIEF

(Violations of the Americans with Disabilities Act (the "ADA") against DOCCS, OMH, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, Shannan Sullivan, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis)

194. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 193 as if fully set forth in this paragraph.

195. Prior to his death, Amir was a qualified individual with a disability as defined in the ADA. He suffered from mental impairments that substantially limited one or more major life

activities, including but not limited to, thinking, concentrating, and interacting with others; he has records of suffering from such impairments; and/or he was regarded as suffering from such impairments.

196. As a State prisoner, Amir met the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the aforementioned defendants. 42 U.S.C. § 12102(2); 42 U.S.C. § 12131(2).

197. DOCCS and OMH are public entities as defined under 42 U.S.C. § 12131(1)(B).

198. DOCCS, OMH, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson discriminated against Amir by, among other acts and failures to act:

(a) failing to complete a Trauma Assessment Form following discovery that Amir had been sexually abused, as required by OMH policy;

(b) failing to treat Amir's history of sexual abuse through counseling;

(c) discharging Amir from inpatient care to Downstate;

(d) failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of inpatient care at CNYPC; and

(e) failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

199. DOCCS, OMH, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, and Shannan Sullivan discriminated against Amir by, among other acts and failures to act, failing to timely provide Amir with an interview and assessment by an assigned counselor, as required by DOCS Directive #4401; by failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended by his discharge plan from inpatient care at

CNYPC; by failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of incarceration at Downstate; and by failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

200. DOCCS, OMH, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, and the Mid-State/DOCCS Jane and John Does discriminated against Amir by, among other acts and failures to act:

(a) failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC;

(b) failing to enroll Amir in a sex offender treatment program, an ART program, or suicide prevention counseling;

(c) failing to provide Amir with reasonable accommodations so that he could have access to certain services and programs while he was housed in SHU, including, but not limited to, providing him access to a sex offender treatment program, an ART program, and suicide prevention counseling;

(d) transferring Amir out of the RCTP and back into the general population;

(e) transferring Amir to SHU on at least four separate occasions;

(f) failing to provide Amir with required daily SHU cell side contact with an OMH mental health clinician;

(g) failing to offer Amir private out-of-cell encounters with OMH on a bi-weekly basis while he was in SHU;

(h) discontinuing Amir's prescribed psychiatric medication;

(i) failing to prescribe Amir alternative psychiatric medication or alternative anti-depression therapy;

(j) failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of incarceration at Mid-State; and

(k) failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

201. DOCCS, OMH, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis discriminated against Amir by, among other acts and failures to act, failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended by his discharge plan from inpatient care at CNYPC; by failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of incarceration at Great Meadow; and by failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

202. The aforementioned defendants discriminated against Amir on the basis of his disability in violation of the ADA. 42 U.S.C. § 12132.

203. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, Shannan Sullivan, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis are sued in their official capacities only.

204. As a direct and proximate result of the aforementioned acts and failures to act, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain

and suffering, and conscious pain and suffering up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

205. Plaintiff seeks compensatory damages, including pain and suffering, against the aforementioned defendants, in an amount to be determined at trial.

FOURTH CLAIM FOR RELIEF

(Violations of Section 504 of the Rehabilitation Act ("Section 504") against DOCCS, OMH, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, Shannan Sullivan, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis)

206. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 205 as if fully set forth in this paragraph.

207. Prior to his death, Amir was a qualified individual with a disability as defined in the ADA. He suffered from mental impairments that substantially limited one or more major life activities, including but not limited to, thinking, concentrating, and interacting with others; he has records of suffering from such impairments; and/or he was regarded as suffering from such impairments.

208. As a State prisoner, Amir met the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the aforementioned defendants. 29 U.S.C. § 794.

209. DOCCS and OMH are public entities as defined under 42 U.S.C. § 12131(1)(B).

210. DOCCS and OMH receive federal assistance.

211. DOCCS, OMH, Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson discriminated against Amir by, among other acts and failures to act:

(a) failing to complete a Trauma Assessment Form following discovery that Amir had been sexually abused, as required by OMH policy;

(b) failing to treat Amir's history of sexual abuse through counseling;

(c) discharging Amir from inpatient care to Downstate;

(d) failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of inpatient care at CNYPC; and

(e) failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

212. DOCCS, OMH, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, and Shannan Sullivan discriminated against Amir by, among other acts and failures to act, failing to timely provide Amir with an interview and assessment by an assigned counselor, as required by DOCS Directive #4401; by failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended by his discharge plan from inpatient care at CNYPC; by failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of incarceration at Downstate; and by failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

213. DOCCS, OMH, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, and the Mid-State/DOCCS Jane and John Does discriminated against Amir by, among other acts and failures to act:

(a) failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC;

(b) failing to enroll Amir in a sex offender treatment program, an ART program, or suicide prevention counseling;

(c) failing to provide Amir with reasonable accommodations so that he could have access to certain services and programs while he was housed in SHU, including, but not limited to, providing him access to a sex offender treatment program, an ART program, and suicide prevention counseling;

(d) transferring Amir out of the RCTP and back into the general population;

(e) transferring Amir to SHU on at least four separate occasions;

(f) failing to provide Amir with required daily SHU cell side contact with an OMH mental health clinician;

(g) failing to offer Amir private out-of-cell encounters with OMH on a bi-weekly basis while he was in SHU;

(h) discontinuing Amir's prescribed psychiatric medication;

(i) failing to prescribe Amir alternative psychiatric medication or alternative anti-depression therapy;

(j) failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of incarceration at Mid-State; and

(k) failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

214. DOCCS, OMH, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis discriminated against Amir by, among other acts and failures to act, failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended by his discharge plan from inpatient care at CNYPC; by failing to provide Amir with adequate and appropriate services, diagnoses, and treatment during his period of incarceration at Great Meadow; and by failing to keep Amir safe from risks of self-harm arising from his mental illness and mental health needs.

215. The aforementioned defendants discriminated against Amir solely on the basis of his disability in violation of Section 504. 29 U.S.C. § 794.

216. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, the Downstate/DOCCS Jane and John Does, Dr. Robert Bakall, Shannan Sullivan, Lieutenant DeRider, Lieutenant Dubernecki, D.S.S. Ward, Captain Christopher J. Holmer, the Mid-State/DOCCS Jane and John Does, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Great Meadow/DOCCS Jane and John Does, and Dr. Danielle Dill-Lewis are sued in their official capacities only.

217. As a direct and proximate result of the aforementioned acts and failures to act, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

218. Plaintiff seeks compensatory damages, including pain and suffering, against the aforementioned defendants, in an amount to be determined at trial.

FIFTH CLAIM FOR RELIEF

(Common Law Negligence against Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lewis Richard Davis, the Mid-State/Medical Jane and John Does, Zoe Kingsley, and Dr. Danielle Dill-Lewis)

219. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 218 as if fully set forth in this paragraph.

220. The aforementioned defendants have a duty of care to protect inmates and patients in their care from injury.

221. In addition, when it is known or should be known that an inmate is a risk of suicide or self-harm, the aforementioned defendants' duty of care includes the provision of reasonable care to prevent such harm.

222. The aforementioned defendants had actual knowledge of Amir's history of attempted suicide and his risk of self-harm, including, but not limited to, the risk that Amir would commit suicide.

223. The aforementioned defendants had actual knowledge of multiple suicide risk factors for Amir.

224. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson breached their duty to Amir by, among other acts and failures, failing to complete a Trauma Assessment Form following discovery that Amir had been sexually abused.

225. Dr. Robert Bakall and Shannan Sullivan breached their duty to Amir by, among other acts and failures, failing to provide Amir with continuity of care and treatment throughout his period of incarceration.

226. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham had actual and constructive knowledge of the deleterious impact of SHUs on the stability of patients with

mental illness, that Amir had spent a significant amount of time in SHU, and that Amir was being transferred from the SHU at Mid-State to the SHU at Great Meadow to complete seven months SHU time. They breached their duty to Amir by, among other acts and failures, engaging in the following independent and equally negligent actions:

(a) allowing Amir to be placed in SHU despite their actual and constructive knowledge of the deleterious effect SHU has on inmates suffering from mental health illness;

(b) failing to provide Amir with continuity of care and treatment throughout his period of incarceration, including, but not limited to, failing to ensure that Amir's care and treatment remained continuous and consistent after his transfer to Mid-State;

(c) failing to provide Amir with required daily SHU cell side contact with an OMH mental health clinician;

(d) failing to offer Amir private out-of-cell encounters with OMH on a bi-weekly basis while he was in SHU;

(e) failing to follow internal protocols in treating, housing, and/or transferring Amir;

(f) failing to enroll Amir in a sex offender treatment program, an ART program, and/or a suicide counseling program, as recommended by his counselor at Downstate;

(g) allowing Amir to be transferred to Great Meadow on a Friday afternoon when it knew that OMH clinicians would not be available to meet with Amir over the weekend;

227. Lewis Richard Davis breached his duty to Amir by, among other acts and failures, failing to notify Great Meadow and/or the OMH staff at Great Meadow about Amir's behavior prior to his transfer, including, but not limited to, his refusal to accept draft, his refusal to communicate with staff prior to his transfer, and the need to use chemical agents to forcibly extract him from his cell at Mid-State.

228. The Mid-State/Medical Jane and John Does breached their duty to Amir by, among other acts and failures, failing to inform OMH about important medical information and changes in Amir's medical medication.

229. Zoe Kingsley breached her duty to Amir by, among other acts and failures, failing to administer to Amir a proper health screening upon his arrival at Great Meadow, as required by DOCS Division of Health Services Policy #1.44; and by falsely representing that Amir had been given the required health screening upon his arrival at Great Meadow and had been immediately referred to OMH.

230. Dr. Danielle Dill-Lewis breached her duty to Amir by, among other acts and failures, failing to ensure that Amir was provided with appropriate medical care and/or monitoring immediately following his June 18, 2010 transfer to Great Meadow.

231. As a direct and proximate result of the aforementioned acts of negligence, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

232. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

SIXTH CLAIM FOR RELIEF

(Common Law Ministerial Neglect against Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lewis Richard Davis, the Mid-State/Medical Jane and John Does, and Zoe Kingsley)

233. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 232 as if fully set forth in this paragraph.

234. The aforementioned defendants have a ministerial duty to care for their inmates.

235. The aforementioned defendants breach their ministerial duty when administrative protocols are violated.

236. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson breached their ministerial duty by, among other actions and failures, failing to complete a Trauma Assessment Form following discovery that Amir had been sexually abused (OMH Policy #9.15).

237. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham breached their ministerial duty by, among other actions and failures:

(a) failing to allow Amir to participate in his treatment plan (OMH Policy #9.22);

(b) failing to document Amir's psychiatric progress and/or his prescribed medications (OMH Policy #9.27);

(c) failing to provide Amir his daily SHU cell side contact with a mental health clinician (OMH Policy #6.0);

(d) failing to offer Amir private out-of-cell encounters with OMH on a bi-weekly basis while he was in SHU;

(e) failing to properly complete Amir's Termination/Transfer Progress notes

prior to transferring Amir to Great Meadow (CBO Policy #9.31)

238. The Mid-State/Medical Jane and John Does breached their ministerial duty by, among other actions and failures, failing to inform OMH about important medical information and changes in Amir's medical medication.

239. Zoe Kingsley breached her ministerial duty by, among other actions and failures, failing to administer to Amir a proper health screening upon his arrival at Great Meadow (DOCS Division of Health Services Policy #1.44).

240. As a direct and proximate result of the aforementioned acts of ministerial neglect, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010 including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

241. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

SEVENTH CLAIM FOR RELIEF

(Common Law Medical Malpractice/Malpractice in the Provision of Mental Health Services against Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Mid-State/Medical Jane and John Does, and Dr. Danielle Dill-Lewis)

242. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 241 as if fully set forth in this paragraph.

243. The aforementioned defendants provided medical and/or mental health services to Amir and were required to possess and use a reasonable degree of skill and competence in caring for and treating Amir.

244. The care and treatment rendered by the aforementioned defendants was negligent, careless, and reckless.

245. The aforementioned defendants were negligent and committed medical malpractice/malpractice in the provision of mental health services by, among other acts and failures,

(a) failing to provide Amir with a continuity of care and treatment throughout his period of incarceration;

(b) failing to accurately and/or consistently diagnosis Amir's mental illness;

(c) failing to properly and/or consistently treat Amir after he reported his history of sexual abuse to CNYPC and repeatedly asked to be placed in a sex offender treatment program;

(d) failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC to prison;

(e) failing to properly treat Amir's mental illness, including, but not limited to, failing to properly prescribe medication to treat Amir's mental illness and/or failing to monitor the effects of prescribed medications;

(f) failing to ensure that Amir remained in psychiatric inpatient care at CNYPC;

(g) failing to perform formal psychological testing on Amir;

(h) failing to adequately document Amir's psychiatric progress and/or his prescribed medications;

246. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham were additionally negligent and committed medical malpractice/malpractice in the provision of mental health services by, among other acts and failures:

(a) failing to reassess the appropriateness of placing Amir in SHU;

(b) changing Amir's MHSL designation from a 1 to a 2; and

(c) failing to enroll Amir in a sex offender treatment program, an ART program, and/or a suicide counseling program, as recommended by his counselor at Downstate;

247. The Mid-State/Medical Jane and John Does were additionally negligent and committed medical malpractice by, among other acts and failures, failing to inform OMH about important medical information and changes in Amir's medical medication.

248. Dr. Danielle Dill-Lewis was additionally negligent and committed medical malpractice/malpractice in the provision of mental health services by, among other acts and failures, failing to ensure that Amir was provided with appropriate medical care and/or monitoring upon his June 18, 2010 transfer to Great Meadow.

249. The aforementioned actions and failures are a deviation and/or departure from accepted community standards of medical practice/practice in the provision of mental health services.

250. These deviations and/or departures from accepted community standards of medical practice/practice in the provision of mental health services directly and proximately caused Amir to suffer damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering, up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

251. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

EIGHTH CLAIM FOR RELIEF

(Common Law Wrongful Death against Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, the Mid-State/Medical Jane and John Does, Lewis Richard Davis, Zoe Kingsley, and Dr. Danielle Dill-Lewis)

252. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 251 as if fully set forth in this paragraph.

253. Plaintiff is the natural mother of Amir and has been appointed the administratrix of Amir's estate.

254. The negligence described herein constitutes wrongful death, actionable under the laws of New York. N.Y. Est. Powers & Trusts Law § 5-4.1.

255. The ministerial neglect described herein constitutes wrongful death, actionable under the laws of New York. Id.

256. The medical malpractice/malpractice in the provision of mental health services described herein constitutes wrongful death, actionable under the laws of New York. Id.

257. At the time of his death, Amir left surviving him his family at law for whose benefit this claim is asserted.

258. At the time of his death, Amir was only 23 years old, held the prospect of contributing to his family, and had been working towards doing so. By virtue of his wrongful death, Amir's family was deprived of his comfort and society and of his support, and they have otherwise been economically damaged.

259. By reason of the wrongful death of Amir, it became necessary to bury his remains, and Plaintiff incurred obligations therefore, and she has incurred additional administrative expenses and other expenses in the settlement of the estate of Amir.

260. Plaintiff seeks pecuniary damages for Amir's distributees including, but not limited to, the costs of Amir's funeral and the loss of his earning potential, support, services, and voluntary assistance over the course of his life.

261. Plaintiff seeks punitive damages for Amir's distributees in an amount to be determined at trial.

NINTH CLAIM FOR RELIEF

(Violations of the State Constitution against Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lewis Richard Davis, and Zoe Kingsley)

262. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 261 as if fully set forth in this paragraph.

263. By its policies and procedures and practices, the aforementioned defendants violated the right of Amir, a prisoner with serious mental illness and serious mental health treatment needs, to be free from cruel and unusual punishment as guaranteed by Article One, Section Five of the New York Constitution.

264. As a matter of policy and practice, the aforementioned defendants acted with deliberate indifference to the mental health needs of Amir.

265. The aforementioned defendants had knowledge of Amir's history of mental illness, suicide attempts, and/or sexual abuse. They knew that he was a risk for suicide or failed to discover that he was a risk for suicide.

266. Sarah Nelson, Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, and Julie Hutchinson acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act:

(a) failing to complete a Trauma Assessment Form following discovery that Amir had been sexually abused, as required by OMH policy;

(b) failing to treat Amir in light of his history of sexual abuse, through counseling; and

(c) discharging Amir from inpatient care to Downstate.

267. Dr. Robert Bakall and Shannan Sullivan acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC.

268. Dr. Lawrence Farago, Jill Porter, Karen Tortelet, and Lori Cunningham acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act:

(a) failing to house Amir in a residential mental health treatment program, such as the TrICP, as was recommended in his discharge plan from inpatient care at CNYPC to prison.

(b) failing to enroll Amir in a sex offender treatment program, an ART program, and suicide prevention counseling;

(c) allowing Amir to be transferred out of the RCTP and back into the general population;

(d) transferring Amir to SHU on at least four separate occasions;

(e) discontinuing Amir's prescribed psychiatric medication;

(f) failing to prescribe Amir alternative psychiatric medication or alternative anti-depression therapy;

(g) failing to inform Great Meadow of the forcible extraction of Amir from his cell prior to his transfer.

269. Lewis Richard Davis acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to ensure that Amir was seen by OMH staff or other mental health personnel following his forced cell extraction and by failing to ensure that Great Meadow was informed of the forced cell extraction.

270. Zoe Kingsley acted with deliberate indifference to Amir's serious medical needs by, among other acts and failures to act, failing to administer the required health screening to Amir at the time he was received at Great Meadow, by falsely reporting that she had administered the required health screening, and by falsely reporting that she had immediately referred Amir to OMH.

271. As a direct and proximate result of the aforementioned acts and failures to act, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010 including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

272. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

TENTH CLAIM FOR RELIEF

(Violations of the State Constitution against Fischer, Hogan, Hulihan, and Kelly)

273. Plaintiff repeats and re-alleges the allegations set forth in paragraphs 1 through 272 as if fully set forth in this paragraph.

274. By its policies and procedures and practices, the aforementioned defendants violated the right of Amir, a prisoner with serious mental illness and serious mental health treatment needs, to be free from cruel and unusual punishment as guaranteed by Article One, Section Five of the New York Constitution.

275. As a matter of policy and practice, the aforementioned defendants acted with deliberate indifference to the mental health needs of Amir.

276. Fischer, Hogan, Hulihan, and Kelly developed and implemented a system of mental health care that they knew was contrary to good and accepted psychiatric treatment in that it permits incarcerating patients with known mental illnesses into SHUs without providing them with adequate mental health treatment.

277. Fischer, Hogan, Hulihan, and Kelly knew that the system they developed and implemented caused mentally ill inmates to be incarcerated in SHUs even though such incarceration was known to have a debilitating effect on the inmates' psychiatric well-being. The actions by Fischer, Hogan, Hulihan, and Kelly led to an increased risk of suicide among mentally ill inmates who were incarcerated in SHUs.

278. By implementing and effecting such a policy, Fischer, Hogan, Hulihan, and Kelly demonstrated deliberate indifference towards Amir's serious medical needs, including his increased risk of self-harm and/or suicide.

279. In addition, Fischer, Hogan, Hulihan, and Kelly acted with deliberate indifference to Amir's serious medical needs by failing to adequately train and supervise Sarah Nelson,

Yolanda Peroni, Marilyn Stemen, Nicole Hunter, Kelly DeHimer, Julie Hutchinson, Dr. Robert Bakall, Shannan Sullivan, Dr. Lawrence Farago, Jill Porter, Karen Tortelet, Lori Cunningham, Lewis Richard Davis, and Zoe Kingsley regarding, among other things:

(a) following and implementing DOCCS and OMH policies;

(b) documenting all treatment and changes in treatment;

(c) communicating all treatment and changes in treatment to all necessary employees;

(d) evaluating inmates, including inmates with mental illnesses, for suicide risk;

(e) recognizing signs of suicide risks among inmates, including inmates with mental illnesses;

(f) diagnosing and treating inmates with mental illnesses;

(g) ensuring that inmates' psychiatric care, diagnoses, and/or treatment remains consistent during and after facility transfers;

(h) screening inmates for suicidal tendencies upon entry into SHUs; and

(i) processing inmates during transfers among facilities.

280. As a direct and proximate result of the aforementioned acts and failures to act, Amir died by apparent suicide and suffered damages in the form of physical injuries, mental pain and suffering, and conscious pain and suffering up to and during his death on June 20, 2010, including, but not limited to, the pain and suffering caused by the failure to properly treat his mental health needs.

281. Plaintiff seeks compensatory damages, including pain and suffering, and punitive damages against the aforementioned defendants, in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court enter judgment against Defendants:

(a) Awarding compensatory damages to Amir's estate in an amount to be determined at trial sufficient to account for Amir's physical injuries, mental pain and suffering, and conscious pain and suffering;

(b) Awarding Amir's distributees funeral expenses and other pecuniary damages arising from his wrongful death;

(c) Awarding Amir's estate and his distributees punitive damages in an amount to be determined at trial;

(d) Awarding Plaintiff costs, disbursements, and attorneys' fees in connection with this action;

(e) Awarding Amir's estate and his distributees pre- and post-judgment interest; and

(f) Granting such other and further relief as this Court deems just and proper.

DATED: New York, New York
November 1, 2012

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